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July 1, 2024

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-32

The following acronyms are contained in this letter:

- DDS - Department of Disability Services
- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security Plan
- MAGI – Modified Adjusted Gross Income
- MN – Medically Needy
- SSI – Supplemental Security Income
- TN – Transmittal

TN #DMAS-32 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after July 1, 2024.

The following changes are contained in TN #DMAS-32:

Changed Pages	Changes
Subchapter M0210	Remove requirement to apply for other benefits per final rule eff 6/3/24
Subchapter M0220.001	Remove limitation on reasonable opportunity periods (ROP) and extend timeframe for Ukrainian Humanitarian Parolees
Subchapter M0220.500	Remove requirement to apply for other benefits per final rule eff 6/3/24
Subchapter M0230.204	Virginia residency continues when custody is held by the LDSS but the child is placed out of state in a trial home visit with parents.
Subchapter M0240.100	Remove limitation on reasonable opportunity periods (ROP) and extend timeframe for Ukrainian Humanitarian Parolees
Subchapter M0240.200	Clarify deemed child can continue past one with no SSN if in a period of Continuous Eligibility
Subchapter M0270	Remove requirement to apply for other benefits per final rule eff 6/3/24

Subchapter M0280	Correct broken link to DJJ facilities
Subchapter M0310.102	Correct formatting for A.2
Subchapter M0310.112	Update Department of Disability Services procedures
Subchapter M0310 Appendix 1	Update DDS contact information
Subchapter M0320.400	Remove SSI and 1619(b) recipients from Medicaid Works automatic eligibility. Clarify they must meet income and resource limits to enter the program. Note that the WIN account cannot be a joint account and that children are not included in the assistance unit for Medicaid Works. Update 2024 1619(b) threshold. Clarify that transfer policy does not apply to Medicaid Works. MW participants cannot be enrolled in a DD Waiver. If the person is already enrolled Medicaid, a new application is not required. Appendix D should be completed to gather additional information on resources. If the person is not currently enrolled in Medicaid, a new application is needed.
Subchapters M0330.001 B M0330.109	Update hierarchy so individuals go to Former Foster Care first as of January 2023
Subchapter M0330.105 B	Correct sequence of subsections
Chapter M04	Add information about how to count lottery and gambling winnings
Subchapter M0810	Medically Needy income limit updates
Subchapters M1110.001, M1110.600, M1140.010, S1140.020	Add information about resource reasonable compatibility
Subchapter M1460.160 B.	Correct references regarding LTSS insurance
Subchapter M1480.225	A claim of undue hardship cannot be made on a denied or closed Medicaid case or when the individual is deceased. If the applicant cannot complete the Resource Assessment due to a medical condition, a physician's statement must be provided documenting the medical condition.
Subchapter M1510.101D.	Update to 20%, still said 10% for income reasonable compatibility

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Sara Cariano, Director, DMAS Eligibility Policy & Outreach Division, at sara.cariano@dmas.virginia.gov or (804) 229-1306.

Sincerely,

Sarah Hatton

Sarah Hatton, M.H.S.A.
Deputy of Administration

Attachment

M02 Table of Contents Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page ii
TN #DMAS-24	7/1/22	Page i
TN #DMAS-15	1/1/20	Pages i, ii
TN #DMAS-10	10/1/18	Page ii
TN #95	3/1/11	Page i
Update (UP) #2	8/24/09	Page ii

M0250.000 ASSIGNMENT OF RIGHTS AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT REQUIREMENTS

M0260 RESERVED

NOTE: Policy references to M0260 that are still in effect have been moved to subchapter M0250.

M0270.000 APPLICATION FOR OTHER BENEFITS -*Subchapter Removed 07/2024*

M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

M0290.000 HIPP REQUIREMENTS—Subchapter Removed 08/2009

M0210 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/23	Page 1
TN #DMAS-18	1/1/21	Page 4
TN #DMAS-2	10/1/16	Page 4
TN #98	10/1/13	Pages 1-3
TN #97	9/1/12	Page 3
Update (UP) #2	8/24/09	Pages 1, 2

M0210.000 GENERAL RULES & PROCEDURES

M0210.001 PRINCIPLES OF MEDICAID ELIGIBILITY DETERMINATION

A. Introduction

Medicaid is an assistance program which pays medical service providers for services rendered to eligible needy individuals. An individual's need for medical care, the state of his health, or his coverage by private health insurance, have no effect on his Medicaid eligibility.

The eligibility determination consists of an evaluation of an individual's situation which compares each of the individual's circumstances to an established standard or definition. The evaluation provides a structured decision-making process. An individual must be evaluated for eligibility in all covered groups for which he meets the definition, and the applicant/enrollee shall be informed of all known factors that affect eligibility.

B. Eligibility Requirements

Although all the requirements that follow may not be applicable in a particular individual's situation, they must be looked at and evaluated.

1. Nonfinancial Eligibility Requirements

The Medicaid nonfinancial eligibility requirements are:

a. Legal presence in the U.S., effective January 1, 2006 (M0210.150).
b. Citizenship/alien status (M0220).
c. Virginia residency (M0230).
d. Social Security number (SSN) provision/application requirements (M0240).
e. Assignment of rights to medical benefits and pursuit of support from the absent parent requirements (M0250).
f. Institutional status requirements (M0280).
g. Covered group requirements (M03).

2. Financial Eligibility Requirements

The Medicaid financial eligibility requirements are:

a. Asset transfer for individuals who need long-term care (subchapter M1450).

b. Resources within resource limit appropriate to the individual's covered group. (Chapter M06 for F&C covered groups; Chapter S11 for ABD covered groups).

c. Income within income limit appropriate to the individual's covered group. (Chapters M04 and M07 for F&C covered groups; Chapter S08 for ABD covered groups).

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 1, 4-6a, Appendices 1, 4 & 5
TN #DMAS-30	1/1/24	Page 3; Appendix 4, page 1
TN #DMAS-27	4/1/23	Page 17 Appendix 4, page 1 Appendix 5, page 1
TN #DMAS-25	10/1/22	Table of Contents, Page 14d. Page 22 Appendix 4 added page 2.
TN #DMAS-24	7/1/22	Table of Contents Pages 1, 4a, 4b, 5, 6a, 8, 14d, 14e, 15, 17, 18, 21, 22, 23 Page 6b was added as a runover page. Appendix 9 was added. Pages 22a and 24-25 were removed.

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

This subchapter explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as "full benefit aliens") or emergency services only (referred to as "emergency services aliens"). The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non-citizens of the United States. These changes eliminated the "permanently residing under color of law" (PRUCOL) category of aliens. The Medicaid benefits for which an alien is eligible are based upon whether or not the alien is a "qualified" alien as well as the alien's date of entry into the United States.

With some exceptions, the Deficit Reduction Act of 2005 (DRA) required applicants for Medicaid and Medicaid recipients to verify their United States citizenship and identity to be able to qualify for Medicaid benefits. The citizenship and identity (C&I) verification requirements became effective July 1, 2006. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows additional exemptions from the C&I verification requirements and provides states with the option to verify C&I through the use of an electronic data match with the Social Security Administration (SSA). It also requires states to enroll otherwise eligible individuals prior to providing C&I verification or immigration status, and grant them *one or more* "reasonable opportunity" period*s* after enrollment to provide documentation, if necessary.

The policy and procedures for determining whether an individual is a citizen or a "full-benefit" or "emergency services" alien are contained in the following sections:

M0220.100 Citizenship & Naturalization;
M0220.200 Alien Immigration Status
M0220.300 Full Benefit Aliens
M0220.400 Emergency Services Aliens
M0220.500 Aliens Eligibility Requirements
M0220.600 Aliens Entitlement & Enrollment
M0220, Appendix 9 Emergency Services Aliens Entitlement & Enrollment

B. Declaration of Citizenship/Alien Status

The Immigration Reform and Control Act (IRCA) requires as a condition of eligibility that the adult applicant who is head of the household (with exceptions below) declare in writing under penalty of perjury whether or not the individual(s) for whom he is applying is a citizen or national of the United States, and if not, that the individual is a lawfully admitted alien. For children under 18 years of age, the declaration is made by an adult family member. The declaration statement is on the application form.

EXCEPTION: An individual who is an "unqualified" alien (as defined in section M0220.410) does NOT complete the declaration.

Individuals who are required to sign the declaration and who fail or refuse to sign are NOT eligible for any Medicaid services.

(MMIS) and SSA for the documentation of C&I for individuals enrolled in the Medicaid and FAMIS programs. In order for this process to be used to verify citizenship and identity, the individual's SSN must be verified by SSA (see M0240).

For eligibility determinations processed through VaCMS, the Social Security data match takes place when the individual's information is sent through the Hub. For cases not processed in VaCMS, the SSA data match will take place after the individual has been enrolled in MMIS.

1. MMIS Data Matches SSA

If the information in the MMIS matches the information contained in the SSA files, the MMIS will be updated to reflect the verification of C&I. No further action is needed on the part of the eligibility worker, and the enrollee will not be required to provide any additional documentation, if the SSA match code in MMIS shows that SSA verified the individual's C&I.

2. MMIS Data Does Not Match SSA

If the information in the MMIS does not match the information in the SSA files, a discrepancy report will be generated monthly listing the inconsistent information. Eligibility staff is expected to review the report to see if the report lists any enrollees who were rejected because SSA could not verify the enrollee's citizenship and identity.

a. SSA Cannot Verify C&I

If the SSA data match result does not verify the individual's C&I, eligibility workers must review the information in the system to determine if a typographical or other clerical error occurred. If it is determined that the discrepancy was the result of an error, steps must be taken to correct the information in the system so that SSA can verify C&I when a new data match with SSA occurs in the future.

If the inconsistency is not the result of a typographical or other clerical error, the individual must be given a reasonable opportunity period of 90 days to either resolve the issue with SSA or provide verification of C&I. The eligibility worker must send a written notification to the enrollee that informs the enrollee of the discrepancy and gives him 90 calendar days from the date of the notice to either resolve the discrepancy with the SSA and to provide written verification of the correction, OR provide acceptable documentation of C&I to the LDSS.

The notice must specify the date of the 90th day, and must state that, if the requested information is not provided by the 90th day, the individual's Medicaid coverage will be canceled. Include with the notice the "Birth Certificates and Proof of Citizenship for Medicaid" Fact Sheet available on at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References. Acceptable forms of documentation for C&I are also included in Appendix 1 to this subchapter.

b. Individual Does Not Provide Verification in 90 Days

If the individual does not *respond to the request and does not* provide the information necessary to meet the C&I documentation requirements by the 90th day, coverage *may* be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period can be provided.*

c. Discrepancy Resolved With SSA Within 90 Days

If written verification is received that corrects the SSA discrepancy within the 90 days, update the system accordingly so that the enrollee's information will be included in a future data match for C&I verification. The individual continues to remain enrolled pending the results of the subsequent data match.

If this subsequent data match with SSA results in verified C&I, MMIS will automatically enter code "CV" in the Cit Lvl and Identity fields in the individual's MMIS record. No further match will be done with the SSA files for C&I verification.

d. Verification of C&I Provided Within 90 Days

If the individual provides acceptable verification of his C&I within the 90 days, update the appropriate demographic fields in MMIS (and ADAPT, if the case is in ADAPT) with the appropriate codes. No further match will be done with the SSA files for C&I verification.

3. Subsequent Applications

If the individual who lost coverage for failure to provide C&I documentation files a subsequent application, a new reasonable opportunity period *should be* granted.

M0220.200 ALIEN IMMIGRATION STATUS

A. Introduction

An alien's immigration status is used to determine whether the alien meets the definition of a "full benefit" alien. All aliens who meet the state residency, covered group and all other nonfinancial eligibility requirements (except SSN for illegal aliens), and who meet all financial eligibility requirements are eligible for Medicaid coverage of emergency services. "Full benefit" aliens may be eligible for all Medicaid covered services. "Emergency services" aliens may be eligible for emergency services only.

B. Procedure

An alien's immigration status must be verified. Use the procedures in sections M0220.201 and 202 below to verify immigration status. After the alien's immigration status is verified, use the policy and procedures in section M0220.300 to determine if the alien is a full benefit alien. If the alien is a full benefit alien and is eligible for Medicaid, use the policy and procedures in section M0220.600 to enroll the alien in Medicaid.

If the alien is an emergency services alien who is eligible for Medicaid, use the policy and procedures in section M0220.600 D to enroll an eligible emergency services alien in Medicaid for emergency services only.

C. Changes in Immigration Status

If a "full benefit" alien who was admitted to the U.S with immigration status in one of the "seven-year" alien groups listed in M0220.313.A becomes a Lawful Permanent Resident, he is considered to have full benefit status for the purposes of Medicaid eligibility for the first seven years of residency in the U.S.

M0220.201 IMMIGRATION STATUS VERIFICATION

A. Verification Procedures

An alien's immigration status is verified by the official document issued by the United States Citizenship and Immigration Services (USCIS) and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. SAVE interfaces with the Federal Hub for applications processed in VaCMS. The EW does not need to obtain the alien status document when immigration status is verified through the Hub. If immigration status cannot be verified through the Hub, the EW must see the original document or a photocopy; submission of just an alien number is NOT sufficient verification.

If the alien has an alien number but no USCIS document, or has no alien number and no USCIS document, use the **secondary verification** SAVE procedure in M0220.202 below if the alien provides verification of his or her identity.

If the agency cannot promptly verify immigration status of an individual in the Hub/SAVE, the agency must provide a 90-calendar-day reasonable opportunity period for the individual's immigration status to be verified and may not delay, deny, reduce or terminate benefits for an individual whom the agency determines to be otherwise eligible for Medicaid during such reasonable the opportunity period.

If the individual does not *respond to the request and does not* provide the information necessary to meet the C&I documentation requirements by the 90th day, coverage *may* be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period can be provided.*

NOTE: If the alien claims to be an illegal alien, do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the illegal alien's eligibility.

B. Documents That Verify Status

Appendix 7 to this subchapter contains a list of typical immigration documents used by lawfully present aliens.

Verify lawful permanent resident status by a Resident Alien Card or Permanent Resident Card (Form I-551), or for recent arrivals a temporary I-551 stamp in a foreign passport or on Form I-94.

Verify lawful admission by a Resident Alien Card (issued from August 1989 until December 1997) or Permanent Resident Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1). Afghan and Iraqi immigrants admitted to the U.S. under a Special Immigrant Visa will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation.

Form I-151 (Alien Registration Receipt Card – the old aka "green card"), Form AR-3 and AR-3a are earlier versions of the Resident Alien Card (Form I-551). An alien with one of the older cards who does not have an I-551should be referred to USCIS to obtain the application forms for the I-551. The forms may be ordered by calling 1-800-375-5283. When an I-151 is presented, refer the alien to USCIS, but accept the document for further verification (see M0220.201.E below).

C. Letters that Verify Status

The USCIS and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with USCIS forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For USCIS letters, contact the USCIS at 1-800-375-5283 for assistance in identifying the alien's status. For ORR letters, contact the toll-free ORR Trafficking Verification Line at 866-401-5510 (see Appendix 2 of this subchapter). Do not verify ORR letters via the SAVE system.

D. Local USCIS Office Documents

Some USCIS offices have developed their own stamps. Therefore, it is possible that a locally produced stamp or legend will be on an USCIS form. If there is any question as to the veracity or status of the document, contact USCIS.

E. Expired or Absent Documentation

If an applicant presents an expired USCIS document or is unable to present any document showing his immigration status, refer the individual to the USCIS district office to obtain evidence of status **unless** he provides an alien registration number. Allow the individual a 90-calendar-day reasonable opportunity period to provide the documentation.

If the individual meets all other Medicaid eligibility requirements, do not delay, deny, reduce or terminate the individual's eligibility for Medicaid **on the basis of alien status**. If the individual does not *respond to the request and does not* provide the information necessary to meet the C&I documentation requirements by the 90th day, coverage *may* be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period can be provided.*

If the applicant provides an alien registration number with supporting verification of his identity, use the SAVE procedures in M0220.202 below to verify immigration status.

If an applicant presents an expired I-551 or I-151, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551 or I-151, follow procedures for initiating a secondary verification.

If the alien does not provide verification of his identity, his immigration status cannot be determined, and he must be considered an unqualified alien.

M0220.202 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE)

A. SAVE

Aliens must submit documentation of immigration status before eligibility for the full package of Medicaid benefits can be determined. SAVE interfaces with the Federal Hub for applications processed in VaCMS. The following procedures are applicable when immigration status cannot fully be verified by the Hub.

If the documentation provided appears valid and meets requirements, eligibility is determined based on the documentation provided AND a comparison of the documentation provided with immigration records maintained by the USCIS. The comparison is made by using the SAVE system established by Section 121 of the Immigration Reform and Control Act of 1986 (IRCA).

1. Primary Verification

Primary verification is the automated method of accessing the USCIS data bank. SAVE regulations require that automated access be attempted prior to initiating secondary verification. There are some specific instances, however, when the agency will forego the primary verification method and initiate secondary verification (see **Secondary Verification**).

A separate form must be completed for each alien. Completely legible copies (front and back) of the alien immigration documents must be stapled to the upper left corner of Form G-845. Copies of other documents used to make the initial alien status determination such as marriage records or court documents must also be attached.

Once the requirement to obtain secondary verification is determined, the agency must initiate the request within ten work days. The USCIS mailing address is subject to frequent changes. Obtain the current mailing address from the SAVE web site at http://www.uscis.gov. Click on "Direct Filing Addresses for Form G-845."

A photocopy of the completed G-845 form must be filed in the record as evidence that the form has been forwarded to USCIS.

The USCIS maintains a record of arrivals and departures from the United States for most legal entrants, and LDSS can obtain the required information from their USCIS office. The USCIS does not maintain an arrival and departure record for Canadian and Mexican border crossers. For these immigrants, as well as immigrants whose status was adjusted and whose original date of entry cannot be verified by USCIS, LDSS will need to verify continuance presence by requiring the immigrant to provide documentation showing proof of continuous presence.

Acceptable documentation includes:

- letter from employer
- school or medical records
- series of pay stubs
- shelter expense receipts, such as utility bills

in the immigrant's name that verify continuous presence for the period of time in question.

C. Agency Action

When the primary verification response requires the eligibility worker to initiate a secondary verification from USCIS, do not delay, deny, reduce or terminate the individual's eligibility for Medicaid **on the basis of alien status**. If the applicant meets all other Medicaid eligibility requirements, approve the application and enroll the applicant in Medicaid. Allow 90 calendar days for the secondary verification to be received. If the secondary verification or the individual do not provide the information necessary to meet the documentation requirements by the 90th day, coverage *may* be canceled. Send an advance notice and cancel coverage at the end of the month in which the 90th day occurs. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period can be provided.*

Upon receipt of the G-845 or response to the on-line query, compare the information with the case record. Timely notice must be given to the individual when Medicaid benefits are denied or reduced.

3. Failure to Provide Requested Verifications

Failure to provide satisfactory evidence of citizenship and identity, after being provided a reasonable opportunity to present such documentation, *may* result in the termination of MA.

An enrollee who fails to cooperate with the agency in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by a recipient or that individual's representative, after being notified, to take a required action within the reasonable opportunity time period. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period can be provided.*

4. Notification Requirements

Prior to the termination of benefits, the enrollee must be sent written notice at least 10 calendar days (plus one day for mailing) prior to the effective date of the closure.

A Notice of Action and appeal rights must be sent to an individual whose application is denied because of failure to provide citizenship and/or identity verification.

5. Maintain Documents in Case Record

The agency must maintain copies of the documents used to verify citizenship and identity in the individual's case record or data base and must make the documents available for state and federal audits.

6. No Reporting Requirements

There are no monthly reporting requirements. However, the Medical Assistance Program Consultants may conduct reviews of cases where eligibility was denied or terminated because of lack of citizenship and/or identity verification.

7. Refer Cases of Suspected Fraud to DMAS

If documents are determined to be inconsistent with pre-existing information, are counterfeit, or are altered, refer the individual to DMAS for investigation into potential fraud and abuse. See section M1700.200 for fraud referral procedures.

Ukraine Humanitarian Parolees

The U.S. Department of Homeland Security (DHS) is providing support and humanitarian relief to Ukrainians who have been displaced by Russia's February 24, 2022 invasion and fled Ukraine. The United States Congress passed the Additional Ukraine Supplemental Appropriations Act (AUSAA) and was signed on May 21, 2022 by President Biden. *It was extended by the Ukraine Security Supplemental Appropriations Act, 2024.* This measure confers eligibility for all Ukrainian Humanitarian Parolees for mainstream federal benefits as well as resettlement services funded by the Office Refugee Resettlement (ORR).

Certain Ukraine nationals entering the U.S. may be eligible for health coverage through Medicaid, the Children's Health Insurance Program (CHIP), the Health Insurance Marketplace, or Refugee Medical Assistance (RMA). These individuals may be granted a range of lawful non-citizen statuses, including parole, temporary protected status (TPS), immigrant and nonimmigrant visas, and refugee or asylees. The primary non-citizen immigrant statuses include:

1. Parolees: Ukrainian nationals who enter the United States as parolees on or **between February 24, 2022 and September 30, *2024*** are eligible for Medicaid or CHIP to the same extent as refugees, without a five-year waiting period, if they meet other eligibility requirements. These Ukrainian parolees are considered "qualified non-citizens" for purposes of Medicaid and CHIP eligibility since they are eligible for the same benefits as refugees.

   Ukrainian nationals who are paroled into the U.S. **after September 30, 2023** and are the spouse or child of a parolee described above, or who is the parent, legal guardian, or primary caregiver of a parolee described above who is determined to be an unaccompanied child will also be eligible for Medicaid and CHIP to the same extent as refugees.

   For eligible Ukrainian parolees who entered the United States with parole between February 24, 2022 – Sept 30, 2023, their date of eligibility is May 21, 2022, or their date of parole, whichever is later.
   For eligible Ukrainian parolees who enter the United States with parole between October 1, 2023 – Sept 30, 2024, their date of eligibility is April 24, 2024, or their date of parole, whichever is later.

2. Temporary Protected Status (TPS): Ukrainian nationals (and individuals having no nationality who last habitually resided in Ukraine) are eligible to apply for TPS. This includes Ukrainians granted TPS or have pending applications for TPS and who have been granted employment authorization. The TPS designation is effective **April 19, 2022 and will remain in effect through October 19, 2023**.

3. Refugees: Some Ukrainian nationals may be granted refugee status and resettled into the U.S. are eligible for full Medicaid or CHIP benefits, without application of the five-year waiting period, if they otherwise meet all other Medicaid eligibility requirements.

4. Lawfully Residing individual: Children under age 19 and pregnant women who are in one of the lawfully residing non-citizen alien groups (see M0220.314) and meet the definition of a lawfully residing alien for Medicaid and FAMIS/FAMIS MOMS coverage may be eligible for assistance.

5. Emergency Services: Ukrainian non-citizens who do not qualify for full Medicaid benefits based on their immigration status may be eligible for "emergency services Medicaid" if they meet all other eligibility requirements. An individual eligible only for emergency Medicaid is permitted to enroll in Marketplace coverage if they meet all Marketplace eligibility requirements.

Ukrainian parolees will generally have foreign passports with a DHS stamp admitting them with a PAR, DT, or UHP Class of Admission (COA). DHS will be using the existing COA code DT and PAR for some Ukrainians who were paroled into the U.S. Additional COA code(s) will be programmed into Hub logic in early fall of 2022.

If an individual has attested to eligible immigration status and is found otherwise eligible for Medicaid, but verification of that status cannot be obtained, do not deny or delay coverage. Enroll the individual and give a 90-day reasonable opportunity period.

Code	MEDICAID ALIEN CODE CHART QUALIFIED ALIEN GROUPS	Arrived Before August 22, 1996	Arrived On or After August 22, 1996	
			1st 5 years	After 5 years
A	Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians [Form DD 214-veteran]	Full Benefit A1	Full Benefit A2	Full Benefit A3
B	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have worked 40 qtrs., except Amerasians [I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)]	Full Benefit B1	Emergency Only B2	Full Benefit ***(40 quarter work requirement ended effective 4-1-21)*** B3
C	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have NOT worked 40 qtrs., except Amerasians and citizens of Micronesia, Marshall Islands, Palau [I-327; I-151; AR-3a; I-551; I688B-274 a.12(a)(1)]	Full Benefit C1	Emergency Only C2	**Full Benefit effective 4-1-21 C1**; Emergency Only for months prior to 4-21 C2
CC	Compact of Free Association (COFA) migrants who are citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau.	Full Benefit CC1	Full Benefits effective 12-27-20. CC1; Emergency Only for months prior to 12-20. CC2	Full Benefit effective 12-27-20. CC1; Emergency Only prior to 12-20. CC2
D	Conditional entrants-aliens admitted pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA [I-94]	Full Benefit D1	Emergency Only D2	Full Benefit D3
E	Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5) section 212(d)(5) of INA [I-94; I-688B – 274a(12)(c)(11)] Afghan Special Immigrant Parolees paroled into the United States between July 31, 2021, and September 30, 2023 will have an I-94 form noting SQ or SI Parole (per section 602(B)(1) AAPA/Sec 1059(a) NDAA 2006). They are eligible for full coverage without a 5-year waiting period. See Appendix 4. Ukraine Humanitarian Parolees. See Appendix 4.	Full Benefit E1	Emergency Only E2	Full Benefit E3
I	Battered aliens, alien parents of battered children, alien children of battered parents [U.S. Attorney General]	Full Benefit I1	Emergency Only I2	Full Benefit I3
	QUALIFIED ALIEN GROUPS		1st 7 years	After 7 years
F	Aliens granted asylum pursuant to section 208 of the INA [I-94; I-688B – 274a.12(a)(5)]	Full Benefit F1	Full Benefit F2	Emergency Only F3
G	Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)}, or Amerasians [I-551; I-94; I-688B]	Full Benefit G1	Full Benefit G2	Emergency Only G3
H	Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA [I-688B – 274a.12(a)(10); Immigration Judge's Order]	Full Benefit H1	Full Benefit H2	Emergency Only H3

M0230 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 3
TN #DMAS-2	10/1/16	Pages 1, 6
TN #100	5/1/15	Pages 3, 4
TN #98	10/1/13	Table of Contents pages 3-6 Page 7 was deleted.
TN #97	9/1/12	Page 4
TN #95	3/3/11	Pages 1, 2
TN #93	1/1/10	Page 2

M0230.200 RESIDENCY REQUIREMENTS

M0230.201 INDIVIDUALS UNDER AGE 21

A. Under Age 21 NOT In An Institution

An individual under age 21 is considered a resident of Virginia if he:

a. is married or emancipated from his parents, is capable of indicating intent and is residing in Virginia with the intent to reside Virginia.

b. is not emancipated but is not living with a parent or caretaker and is presently residing in Virginia with the intent to reside in Virginia;

c. lives with a parent or caretaker who is presently residing in Virginia with the intent to reside in Virginia;

d. is a non-IV-E (state/local) foster care child whose custody is held by Virginia (see M230.204 C. and D.);

e. is a non-IV-E foster care child whose custody is held by another state but who has been placed with and is residing in Virginia with a parent or caretaker relative;

f. is a non-IV-E child adopted under an adoption assistance agreement with Virginia (see M230.204 C. and D.);

g. is a non-IV-E foster care child whose custody is held by a licensed, private foster care agency in Virginia, regardless of the state in which the child physically resides;

h. is under age 21 and is residing in another state for temporary period (for reasons such as medical care, education or training, vacation, (or visit) but is still in the custody of his/her parent(s) who reside in Virginia.

i. is living with a parent(s) who is a non-immigrant alien (admitted to the U.S. for a temporary or limited time) when the parent has declared his intent to reside in Virginia permanently or for an indefinite period of time, and no other information is contrary to the stated intent.

j. Is placed out of state for a trial home visit with parents (while custody is retained by Virginia).

B. Under Age 21 In An Institution

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

An institutionalized individual (who was not placed in the institution by a state government) who is under age 21 and is not married or emancipated, is a resident of Virginia if:

1. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;

2. the individual's parent or legal guardian who applies for Medicaid is a Virginia resident and the individual is institutionalized in Virginia; or

3. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, and the individual is institutionalized in Virginia.

M0240 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 3 and 5
TN #DMAS-24	7/1/22	Pages 3-6
TN #DMAS-21	10/1/21	Pages 1, 3, 5
TN #DMAS-20	7/1/21	Table of Contents Pages 1, 3, 5 Page 6a was renumbered to Page 7. Pages 2, 4, 6 and 7 are runover pages.
TN #DMAS-13	7/1/19	Page 1 Pages 2 and 3 are runover pages.
TN #DMAS-10	10/1/18	Pages 3, 4
TN #DMAS-9	7/1/18	Table of Contents Page 6 Page 6a is a runover page
TN #DMAS-2	10/1/16	Pages 1, 4 Page 2 is a runover page.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Table of Contents Pages 1-5 Page 6 was deleted.
TN #96	10/1/11	Pages 2-4
TN #94	9/1/10	Pages 1-6
TN #93	1/1/10	Pages 1-4
Update (UP) #1	7/1/09	Pages 1, 2
TN #91	5/15/09	Pages 1, 2

M0240.100 APPLICATION FOR SSN

A. Policy

If an SSN has not been issued for the individual or the individual's child(ren), the applicant must cooperate in applying for a number with the local Social Security Administration Office (SSA). Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from SSA verifying that the application was submitted. The SS-5 is available online at: http://www.socialsecurity.gov/ssnumber/ss5.htm.

The agency must provide *at least one* 90-calendar-day reasonable opportunity period for the individual to obtain and provide an SSN and may not delay, deny, reduce or terminate benefits for an individual whom the agency determines to be otherwise eligible for Medicaid during such reasonable the opportunity period. If the application for an SSN was made through hospital enumeration, the agency must allow 120 calendar days for the SSN to be obtained and provided.

The applicant must provide the SSN to the local social services department as soon as it is received and the number must be verified and entered in the eligibility/enrollment system.

1. Newborns

In the case of a newborn child, the applicant/recipient may satisfy this requirement by requesting that an SSN be applied for by hospital staff in conjunction with the filing of the birth record at the time of the child's birth. Form SSA-2853 will be given to the mother by hospital staff as verification of application for the child's SSN.

For an infant born to a mother in FAMIS Prenatal Coverage who is assigned to AC 110 and who is in managed care OR who is enrolled in AC 111, see M0240.200 C.

2. Failure to Apply for SSN

Applicants who refuse to furnish an SSN or to show proof of application for a number are ineligible for Medicaid.

3. Retroactive Eligibility

An individual who provides proof of application for an SSN after he applies for medical assistance, meets the application for SSN requirement in the three months retroactive to his medical assistance application.

M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN APPLICATION

A. Applicant Applied for SSN

When an applicant who has applied for an SSN is determined eligible for medical assistance, he is enrolled with a pseudo-SSN. The worker must obtain the enrollee's SSN when it is assigned and enter it into the enrollee's records.

For an infant born to a mother in FAMIS Prenatal Coverage who is assigned to AC 110 and who is in managed care OR who is assigned to AC 111, see M0240.200 C.

d. SSN Not Provided by Renewal Deadline

The worker must assist the enrollee in obtaining the applied-for SSN. The worker will ask the enrollee for the assigned SSN at the first renewal, and give a deadline date for the enrollee to provide the SSN.

If the enrollee does not provide the SSN by the deadline, the worker will ask the enrollee why it was not provided to the worker:

- Did the enrollee ever receive the SSN from SSA?
- If not, why not?

If the problem is **not** an SSA administrative problem, the worker must cancel MA coverage for the enrollee whose SSN is not provided.

C. Follow-Up Procedures For an Infant Born to a Woman Enrolled in FAMIS Prenatal Coverage

An infants born to a mother enrolled in FAMIS Prenatal Coverage assigned to Aid Category (AC) 110 and who is NOT in managed care is a deemed newborn. Follow up on the SSN is not required until the time of the newborn's first renewal *during the month or after turning one.*

An infant born to a mother in FAMIS Prenatal Coverage who is assigned to AC 110 and who IS in managed care OR who is assigned to AC 111 is not a deemed newborn; however, the infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. Follow the procedures in M0240.200 B.3 above 90 days following the infant's enrollment to determine if an SSN has been assigned. If the SSN number has not yet been issued at 90 days, obtain the SSN or proof of application for an SSN at the first renewal of the infant's coverage *during the month or after turning one.*

M0240.300 SSN Verification Requirements

A. SSN Provided By Individual

The individual's SSN must be verified. When the individual provides his SSN, the worker may use the SOLQ-I or SVES to verify the individual's SSN. The individual is not eligible for MA and cannot be enrolled in the eligibility/enrollment system if his SSN is not verified.

B. Procedures

1. Enter Verified SSN in Systems

Enter the eligible enrollee's verified SSN in the eligibility/enrollment system.

2. Resolving Unverified SSN Discrepancies

a. Data Entry Error Caused Discrepancy

If it is determined that the discrepancy was the result of an error made while entering the SSN in the system, steps must be taken to correct the information in the eligibility/enrollment system so that a new data match with SSA can occur in the next month.

M0280 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 7
TN #DMAS-20	7/1/21	Table of Contents Page 1 Appendix 2 was added.
TN #DMAS-19	4/1/21	Pages 3, 4 Appendix 1 Page 4a was added.
TN #DMAS-17	7/1/20	Pages 7, 9, 10 Page 11 was deleted.
TN #DMAS-15	1/1/20	Page 9 Appendix 1
TN #DMAS-14	10/1/19	Pages 6, 7, 9, 11
TN #DMAS-2	10/1/16	Pages 7, 9
TN #100	5/1/15	Table of Contents Pages 1-11 Appendix 1 was added Pages 12 and 13 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Page 8 Appendix 1 was deleted.
TN #94	9/1/10	Page 1
TN #93	1/1/10	Page 13

An offender who transfers temporarily to a halfway house, residential re-entry center (RRC), or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization. Note: some drug or alcohol rehabilitation centers may be referred to as a "halfway house"; the eligibility worker should confirm the individual is not an inmate or incarcerated.

Once an incarcerated individual who is enrolled in Medicaid is released from the correctional facility, he may be eligible for all benefits available under the Medicaid covered group he meets.

D. Juveniles in Detention

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post- disposition situations, and types of facilities.

1. Held for Care, Protection or Best Interest

A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

2. Held for Criminal Activity

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- juvenile who is in a detention center due to criminal activity
- juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site at *Juvenile-Detention-Centers-and-Homes-Contacts.pdf (virginia.gov)*. Because this list is subject to change, consult the list whenever eligibility must be evaluated for a juvenile who is reportedly in a detention center.

If the juvenile goes to a non-secure group home, he can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center.

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 6 and 28 ; Appendix 1
TN #DMAS-29	10/1/23	Page 5
TN #DMAS-26	1/1/23	Pages 2, 28b Appendix 1
TN #DMAS-24	7/1/22	Page 36 Page 37 is a runover page.
TN #DMAS-23	4/1/22	Pages 2, 5, 6, 6a
TN #DMAS-22	1/1/22	Page 28
TN #DMAS-20	7/1/21	Page 6 Pages 5 and 5a are runover pages.
TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.

2. Special Medical Needs

Children with special needs for medical or rehabilitative care adopted under a Non IV-E Adoption Assistance agreement with a Virginia local department of social services or a Virginia private, non-profit child placement agency in conjunction with a local department of social services, in accordance with policies established by the State Board of Social Services *are considered to be residing in Virginia*.

a. Documentation must indicate that the child has special needs for medical or rehabilitative care

One of the following documents must indicate the child's special needs for medical or rehabilitative care:

- an adoption assistance agreement specifying that the child has a special need for medical or rehabilitative care; the agreement does NOT need to specify a particular diagnosis or condition.
- an amendment to the adoption assistance agreement specifying that the child has a special need for medical or rehabilitative care.
- a signed letter on official letterhead from the state that facilitated the adoption assistance agreement confirming that the child has a special need for medical or rehabilitative care.

b. Virginia Medicaid coverage for children with special needs for medical or rehabilitative care

Medicaid coverage is to be provided to any child who has been determined to be a Non-IV-E Adoption Assistance Child with special needs for medical or rehabilitative care for whom there is in effect an adoption assistance agreement between a local Virginia department of social services (LDSS) or a Virginia child-placing agency and an adoptive parent(s).

Virginia Medicaid coverage MAY be provided to a child with special needs for medical or rehabilitative care for whom there is in effect an adoption assistance agreement between another state's child-placing agency and an adoptive parent(s) IF the other state reciprocates with Virginia per the Interstate Compact on Adoption and Medical Assistance (ICAMA).

application is pending for the disability determination. DDS does NOT stop the disability determination when the individual has excess income because of possible spenddown eligibility

4. LDSS Responsibilities for Communication with DDS

The LDSS must make every effort to provide DDS with complete and accurate information and shall report all changes in address, medical condition, and earnings to the DDS on pending applications.

5. Evaluation for Plan First and Referral to Health Insurance Marketplace

While an individual's application is pending during the non-expedited disability determination process, evaluate his eligibility in non-ABD covered groups (e.g. MAGI Adults and Plan First). If the individual is not eligible for full Medicaid coverage, refer the individual to the Health Insurance Marketplace (HIM) for evaluation for the Advance Premium Tax Credit (APTC).

H. Notification of DDS Decision to LDSS

1. Hospitalized Individuals

The DDS will advise the agency of the applicant's disability status as soon as it is determined by either SSA or the DDS. For hospitalized individuals who meet the requirements for an expedited disability determination, DDS will fax the outcome of the disability determination directly to the LDSS responsible for processing the application and enrolling the eligible individual.

2. Individuals Not Hospitalized

For all other disability determinations, DDS will notify the LDSS responsible for processing the application and enrolling the eligible individual by an alert in VaCMS.

3. Disability Cannot Be Determined Timely

A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. DDS will notify the applicant about 75 days from the application date of the delay. DDS will notify the LDSS by an alert in VaCMS. The LDSS must send the applicant a Notice of Action to extend the pending application.

4. DDS Rescinds Disability Denial

DDS may decide to rescind a disability denial when a determination or decision, which appeared to be correct based on the available evidence at the time it was made, is later discovered to have been incorrect. Applicants or Appellants cannot request that the DDS rescind a denial. If an applicant or appellant would like the claim re-evaluated, the individual must appeal the Medicaid decision with DMAS or file a new Medicaid application with DSS. DDS will notify the agency if it rescinds its denial of an applicant's disability to continue an evaluation of the individual's medical evidence. If the Medicaid application has been denied, the agency must reopen the application and notify the applicant of the action. The application continues to pend until notification is received from DDS of the disability determination. If an appeal has been filed with DMAS, the agency must notify the DMAS Appeals Division so that the appeal may be closed (see M1650.100).

I. LDSS Action & Notice to the Applicant

The eligibility worker must complete the Medicaid eligibility determination immediately after receiving notice of the applicant's disability status and send the applicant a Notice of Action regarding the disability determination and the agency's decision on the Medicaid application.

Disability Determination Services (DDS) Contact Information

Send ALL expedited and non-expedited disability referrals to the DDS Central Regional Office.

DDS Regional Office	Hearing Contacts
Central Regional Office Disability Determination Services 9960 Mayland Drive. Suite 200 Richmond, Virginia 23233 Phone: 800-523-5007 or 804-367-4700 FAX: 804-527-452*4* *Operations Manager: Talya Brown* *Professional Relations Officer: Shareen Young-Chavez* *District Director: Elliot Duncan*	Primary Contact *for Scheduling*: *Clint Barrett* *(804) 367-1570* Backup: Patrice Harris 804-367-4714

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 24-26a, 29
TN #DMAS-29	10/1/23	Pages 1, 25, 26, 26a, 27, 28
TN #DMAS-27	4/1/23	Pages 11, 24, 25, 27
TN #DMAS-26	1/1/23	Page 11
TN #DMAS-24	7/1/22	Pages 2, 30, 31, 33
TN #DMAS-23	4/1/22	Page 27
TN #DMAS-22	1/1/22	Pages 11, 26a, 27
TN #DMAS-20	7/1/21	Pages 24, 26-29
TN #DMAS-19	4/1/21	Pages 26a, 29
TN #DMAS-18	1/1/21	Pages 11, 22, 26, 27
TN #DMAS-17	7/1/20	Pages 24. 25. 26, 27 Page 26a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 11, 26, 27, 29
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1; 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49;Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents; Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents; Pages 46f-50b; Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71; Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68

B. Financial Eligibility

1. Assistance Unit The assistance unit policy and procedures in chapter M05 apply to ABD individuals with income less than or equal to 80% FPL. If not institutionalized, deem or count any resources and income from the individual's spouse with whom he lives. If institutionalized with a community spouse, go to subchapter M1480.

2. Resources The resource limit is $2,000 for an individual and $3,000 for a couple.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply to this covered group.

All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.

3. Income The income limits are ≤ 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.

4. Income Exceeds 80% FPL **Spenddown does not apply** to this covered group. If the individual's income exceeds the 80% FPL limit, he is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

D. Entitlement If all eligibility factors are met in the application month, entitlement to full Medicaid coverage in this covered group begins the first day of the application month.

ABD individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period.

E. Enrollment The ABD 80% group AC is:

- 029 for an aged individual;
- 039 for a blind individual;
- 049 for a disabled individual; or
- 109 for all incarcerated individuals.

M0320.400 MEDICAID WORKS

A. Policy The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals to work and earn higher income while retaining Medicaid coverage. This program is called MEDICAID WORKS and includes individuals:

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to 138% FPL **and**
- who have countable resources less than or equal to $2,000 for an individual and $3,000 for a couple; **and**

- who are working or have a documented date for employment to begin in the future.
- Current participation in the Social Security Administration (SSA) programs Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) will satisfy the condition for disability. Any applicant without SSA documentation of disability should be evaluated by the state's Disability Determination Services program before eligibility can be established.

These individuals can retain Medicaid coverage as long as they remain employed and their earned income is less than or equal to $6,250 per month. MEDICAID WORKS is Virginia's Medicaid Buy-In (MBI) program.

B. Relationship Between MEDICAID WORKS and 1619(b) Status

An individual with SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) meet the *138% FPL* income requirement for entry into MEDICAID WORKS and must not be discouraged from enrolling in MEDICAID WORKS. An individual who meets the criteria for 1619(b) status may choose to participate in MEDICAID WORKS because of the higher resource limit. ***SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) individuals are not automatically enrolled in Medicaid Works. They must be evaluated according to the non-financial and financial requirements used for all MEDICAID WORKS applicants and enrollees.***

C. Nonfinancial Eligibility

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities.
  Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.
- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.
- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings account which can be established prior to the application date. The individual must provide documentation for the case record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with only earned income deposited into it. Increases in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR as a result of a COLA adjustment to the Social Security Disability benefits may also be deposited into the WIN account and will be excluded as described in M0320.400 D.3.b.3) as long as the increase is regularly deposited upon receipt into the WIN account.

The WIN account cannot contain the individual's other Social Security benefits. The individual must provide statements from the institution where the account is held at application and renewal.

- *The WIN Account cannot be a jointly owned account; only funds of the MEDICAID WORKS enrollee can deposit into the designated account.*

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. The agreement outlines the individual's responsibilities as an enrollee in the program.

D. Financial Eligibility

1. Assistance Unit

Initial eligibility determination

In order to qualify for MEDICAID WORKS, the individual must meet the assistance unit policy and procedures in chapter M05 that apply to ABD non-institutionalized individuals. Individuals receiving SSI or who have 1619(b) status also meet the income requirement for entry into MEDICAID WORKS.

Income from a non-ABD spouse, non-applicant/member ABD spouse, or parents is **not** considered deemable income and is not counted for the initial eligibility determination for individuals requesting to participate in MEDICAID WORKS.

Resources from the individual's spouse with whom he lives or, if under age 21, the individual's parents with whom he lives, must be deemed available.

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, **the individual is treated as an assistance unit of one.** Spousal and parental resources and income are disregarded for ongoing enrollee eligibility.

Note: *Children are not included in the assistance unit when determining eligibility for MEDICAID WORKS.*

2. Resources

a. Initial eligibility determination

For the initial eligibility determination, the resource limit is $2,000 for an individual and $3,000 for a couple. Resources must be evaluated for all individuals, including SSI recipients and QSII/(1619(b) individuals, who wish to qualify for MEDICAID WORKS. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit.

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following resource policies apply:

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The *2024* 1619(b) threshold amount is *$45,976 (decreased from the 2023 amount)*.

2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical or health savings accounts, medical reimbursement (flex) accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans. The account must be designated as a WIN Account to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees**. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) for the exclusion to continue. Resources can be spent however the individual chooses. Transfers will be evaluated if the individual applies for LTSS.

3) *Resources can be spent however the individual chooses. Transfers will be evaluated to determine if a penalty should be calculated if the individual applies for LTSS.*

4) For **all** other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated.

All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual.

Resources accumulated while in MEDICAID WORKS and retained in an IRS-approved account described in M0320.400 D. 2. b. 2) that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18). *Medicaid Works members cannot be enrolled in* Developmental Disabilities (*DD) waivers but can receive personal care services as a service provided by the assigned MCO plan*; MEDICAID WORKS enrollees do **not** have a patient pay *responsibility*. Intensive Behavioral Dietary Counseling is also covered for MEDICAID WORKS enrollees when a physician determines that the service is medically necessary.

I. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above.

There is no retroactive coverage under MEDICAID WORKS. The application date in the Virginia Case Management System (VaCMS) is the date the individual signed the MEDICAID WORKS Agreement. Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month. *If the person is already enrolled Medicaid, a new application is not required. Appendix D should be completed to gather additional information on resources. If the person is not currently enrolled in Medicaid, a new application is needed*.

The AC for MEDICAID WORKS is 059. Use the following procedures to enroll the individual in VaCMS:

<u>New Application – Applicant is Disabled and enrolled in Medicaid</u>

1. For the month of application and any retroactive months in which the person is eligible, enroll the individual in the appropriate ACin a closed period of coverage, beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.
2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is signed). Use the same application date (the actual date of the initial application) that was used for the month of application.

DMAS approval is not required for participation in MEDICAID WORKS; however, information must be sent to DMAS after the individual is enrolled for tracking purposes. Use the MEDICAID WORKS Email Cover Sheet available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, and **email** it together with the following information to DMAS at **dmasevaluation@dmas.virginia.gov**:

- the signed MEDICAID WORKS Agreement,
- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- one of the following verifications of employment:
  a pay stub showing current employment or an employment letter with start date or self-employment document(s).

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 1a, 4
TN #DMAS-31	4/1/24	Pages 8, 26-28
TN #DMAS-30	1/1/24	Pages 1, 2, 4, 6, 8, 10, 12, 17, 20, 23, 34, 35, 38, 40
TN #DMAS-26	1/1/23	Page 10
TN #DMAS-24	7/1/22	Pages 1, 2, 15, 18, 29, 31, 32 Page 2a was added as a runover page.
TN #DMAS-23	4/1/22	Table of Contents Pages 1, 2, 5, 7, 8, 29, 37, 39, 40
TN #DMAS-20	7/1/21	Pages 1, 13, 14
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

1. If the child is a child under age 1, child under age 18, an individual under age 21 or an adoption assistance child with special needs for medical or rehabilitative care, but has income in excess of the appropriate F&C CN income limit, evaluate as MN.

A determination of eligibility for a F&C adult should follow this hierarchy:

1. *If the individual is a former foster care child under 26 years, evaluate in this covered group.*

2. If the individual meets the definition of a parent/caretaker relative, evaluate in the LIFC covered group.

3. If the individual has been screened and diagnosed with breast or cervical cancer or pre-cancerous conditions by the Every Woman's Life program and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child under 19, evaluate in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group.

4. If the individual is between the ages of 19 and 64 and is not eligible for or entitled to Medicare, evaluate in the MAGI Adults group.

5. If the individual is not eligible as a MAGI Adult, LIFC individual, or pregnant woman but is in a medical institution, has been authorized for Home and Community Based Services or has elected hospice, evaluate in the appropriate F&C 300 % of SSI covered group.

6. If the individual is a parent or caretaker-relative of a dependent child and in a medical institution, the stay must be temporary while receiving treatment, rehabilitation, etc. for him to meet the definition of living in the home with the dependent child. There are no time limits on the amount of time the parent can be in a medical institution as long as he intends to return home. Verify with the parent the reason he is in a medical facility and ask about the intent to return home.

7. If the individual has excess income for full coverage in a Medicaid covered group and is between the ages of 19 and 64, evaluate for Plan First coverage.

8. If the individual is a pregnant woman but has excess income for coverage in a CN group or FAMIS MOMS evaluate as MN.

***G*. Entitlement**

Children under 19 receive 12 months of continuous eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.

1. IV-E Foster Care Child

Entitlement to Medicaid as a IV-E Foster Care child begins the first day of the month of commitment or entrustment if a Medicaid application is filed within 4 months of commitment or entrustment. Retroactive entitlement prior to the month of commitment or entrustment is not allowed.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement may be retroactive up to 3 months prior to application if the child met all Medicaid eligibility requirements in the retroactive months. However, Medicaid entitlement cannot go back to the month of entrustment or commitment when the application is filed more than 4 months after entrustment or commitment.

2. IV-E Adoption Assistance Child

Entitlement to Medicaid as a IV-E Adoption Assistance child begins the first day of the application month if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

***H*. Enrollment**

The aid category (AC) for IV-E foster care children is "076." The AC for IV-E Adoption Assistance children is "072".

M0330.107 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.222 – The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the income requirements of the state's July 16, 1996 AFDC State Plan. Children under age 19 should be evaluated in the FAMIS Plus covered group if not eligible as individuals under age 21.

Individuals ages 19 and 20 should be evaluated in the Individuals Under Age 21 covered group when they are not eligible for Medicaid in any other full-benefit covered group.

The reasonable classifications of individuals under age 21 are:

- IV-E eligible foster care children who do NOT receive a IV-E maintenance payment,
- Non-IV-E foster care children,
- Department of Juvenile Justice (DJJ) children,
- Non-IV-E Adoption Assistance children,
- Children in intermediate care nursing facilities (ICF), and
- Children in intermediate care facilities for the intellectually disabled (ICF-ID).

B. Nonfinancial Eligibility Requirements

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02.

C. Reasonable Classifications

The individual under age 21 must meet one of the following classifications:

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 16; Appendices 3, 5 and 8
TN #DMAS-31	4/1/24	Pages 15 and 16a; Appendices 1, 2, 6 and 7
TN #DMAS-30	1/1/24	Pages 1, 34 Page 34a is a runover page
TN #DMAS-28	7/1/23	Page 37 Appendices 1,2,3,5,6 and 7

g. Effective January 1, 2019, alimony received is not countable.

Alimony received prior to January 1, 2019, is countable. An individual whose divorce decree was finalized prior to January 1, 2019, has the option with the IRS to adopt the new IRS alimony rule by modifying the divorce agreement. If an individual whose divorce decree was finalized prior to January 1, 2019, does not want alimony received on or after January 1, 2019 to be countable for the MAGI income determination, the individual must provide a copy of the modified divorce agreement to the eligibility worker.

h. An amount received as a lump sum is counted only in the month received

i. *Lottery and gambling winnings of $80,000 or greater, which are received in a single payout, are counted not only in the month received, but over a period of up to 120 months. Lottery winnings paid out in installments would be treated the same as other types of recurring income. Winnings less than $80,000 are counted in the month received;*

• Winnings of $80,000 but less than $90,000 are counted as income over two months, with an equal amount counted in each month; and

• For every additional $10,000 one month is added to the period over which total winnings are divided, in equal installments, and counted as income.

The maximum period of time over which winnings may be counted is 120 months, which would apply for winnings of $1,260,000 and above. The requirement to count qualified lottery and gambling winnings in household income over multiple months applies only to the individuals receiving the winnings. The determination of household income for other members of the individual's household are not affected. Thus, for example, the total amount of qualified lottery or gambling winnings of a spouse or parent continues to count only in the month received in determining the eligibility of the other spouse and children. If the winner wishes to claim an"undue medical or financial hardship" exemption to counting the income after the first month, send the request to DMASEvaluation@dmas.virginia.gov.

j. Military pay based upon age or years of service (other types of military pay are also counted and excluded; see M0720.290)

k. Census income.

l. RecognizeB5 Initiative and Incentive Payments issued to educators for their ongoing efforts to improve Virginia's early childcare and education structure are counted.

m. Unemployment Compensation is counted as unearned income.

Exception: Additional benefits of $600 per week paid under the under the Federal Pandemic Unemployment Compensation program *were* not counted. See M0440.100 B.2.n.

2. Income That is not Counted

a. Child support received is not counted as income (it is not taxable income).

b. Workers Compensation is not counted.

LIFC Income Limits Effective *7/1/2024*

Group I

Household Size	Monthly Amount	Annual Amount
1	~~*$307*~~	~~*$3684*~~
2	~~*467*~~	~~*5604*~~
3	~~*592*~~	~~*7104*~~
4	~~*717*~~	~~*8604*~~
5	~~*846*~~	~~*10152*~~
6	~~*952*~~	~~*11424*~~
7	~~*1073*~~	~~*12876*~~
8	~~*1203*~~	~~*14436*~~
Additional	~~*128*~~	~~*1536*~~

Group II

Household Size	Monthly Amount	Annual Amount
1	~~*$402*~~	~~*$4824*~~
2	~~*574*~~	~~*6888*~~
3	~~*720*~~	~~*8640*~~
4	~~*860*~~	~~*10320*~~
5	~~*1011*~~	~~*12132*~~
6	~~*1140*~~	~~*13680*~~
7	~~*1277*~~	~~*15324*~~
8	~~*1413*~~	~~*16956*~~
Additional	~~*145*~~	~~*1740*~~

Group III

Household size	Monthly Amount	Annual Amount
1	~~*$603*~~	~~*$7236*~~
2	~~*805*~~	~~*9660*~~
3	~~*985*~~	~~*11820*~~
4	~~*1156*~~	~~*13872*~~
5	~~*1366*~~	~~*16392*~~
6	~~*1518*~~	~~*18216*~~
7	~~*1690*~~	~~*20280*~~
8	~~*1868*~~	~~*22416*~~
Additional	~~*174*~~	~~*2088*~~

INDIVIDUALS UNDER AGE 21 INCOME LIMITS

EFFECTIVE *7/1/24*

Group I

Household Size	Monthly Income Limit	Annual Income Limit
1	~~*$273*~~	~~*$3,276*~~
2	~~*456*~~	~~*5,472*~~
3	~~*581*~~	~~*6,972*~~
4	~~*705*~~	~~*8,460*~~
5	~~*829*~~	~~*9,948*~~
6	~~*929*~~	~~*11,148*~~
7	~~*1,040*~~	~~*12,480*~~
8	~~*1,179*~~	~~*14,148*~~
Each additional person add	~~*123*~~	~~*1,476*~~

Group II

Household Size	Monthly Income Limit	Annual Income Limit
1	~~*$398*~~	~~*$4,776*~~
2	~~*576*~~	~~*6,912*~~
3	~~*718*~~	~~*8,616*~~
4	~~*861*~~	~~*10,332*~~
5	~~*1,017*~~	~~*12,204*~~
6	~~*1,252*~~	~~*15,024*~~
7	~~*1,277*~~	~~*15,324*~~
8	~~*1,421*~~	~~*17,052*~~
Each additional person add	~~*143*~~	~~*1,716*~~

Group III

Household Size	Monthly Income Limit	Annual Income Limit
1	~~*$529*~~	~~*$6,348*~~
2	~~*707*~~	~~*8,484*~~
3	~~*855*~~	~~*10,260*~~
4	~~*1,001*~~	~~*12,012*~~
5	~~*1,182*~~	~~*14,184*~~
6	~~*1,303*~~	~~*2,606*~~
7	~~*1,446*~~	~~*17,352*~~
8	~~*1,590*~~	~~*19,080*~~
Each additional person add	~~*144*~~	~~*1,728*~~

TREATMENT OF INCOME FOR FAMILIES & CHILDREN COVERED GROUPS

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY; 300% SSI; F&C COVERED GROUPS
Earnings	Counted with no disregards	Counted with appropriate earned income disregards
Social Security Benefits Adult's MAGI household	Benefits received by a parent or stepparent are counted for his eligibility determination, as well as the eligibility determinations of his spouse and children in the home.	Counted if anyone in the Family Unit/Budget Unit receives
Social Security Benefits Child's MAGI household	If the child lives with a parent, only counted if the child is required to file a federal tax return..	Counted if anyone in the Family Unit/Budget Unit receives
Child Support Received	Not counted	Counted – subject to $50 exclusion
Child Support Paid	Not deducted from income	Not deducted from income
Alimony Received	Counted if divorce agreement was finalized prior to January 1, 2019, and the agreement has not been modified.	Counted – subject to $50 exclusion if comingled with child support
Alimony Paid	Deducted from income if divorce agreement was finalized prior to January 1, 2019	Not deducted from income
Worker's Compensation	Not counted	Counted
Veteran's Benefits	Not counted if they are **not** taxable in IRS Publication 525	Counted
Scholarships, fellowships, grants and awards used for educational purposes	Not counted	Not counted
Student Loan Debt	Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income	Not applicable
Foreign Income (whether or not excluded from taxes)	Counted	Counted
Interest	Counted	Counted
Lump Sums	Income in month of receipt	Income in month of receipt
Lottery & Gambling Winnings	*Lottery and gambling winnings of $80,000 or greater, received in a single payout, are counted in the month received and over a period of up to 120 months. Income in month of receipt for other HH members.*	*Income in month of receipt*
Gifts, inheritances, life insurance proceeds	Not counted	Counted as lump sum in month of receipt
Parsonage allowance	Not counted	Counted
Pandemic Unemployment Compensation Payments	Not counted (regular Unemployment Compensation is counted.)	Not counted (regular Unemployment Compensation is counted.)
***Federal* COVID-19 relief payments**	Not counted	Not counted

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 2
TN #DMAS-31	4/1/24	Pages TOC i, 1, 2
TN #DMAS-29	10/1/23	Pages 6, 9
TN #DMAS-28	7/1/23	Pages 2, 6
TN #DMAS-27	4/1/23	Page 2, 25, 27, 28 Page 25a is a runover page
TN #DMAS-25	1/1/23	Pages 1, 2
TN #DMAS-24	7/1/22	Page 2
TN #DMAS-23	4/1/22	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2, 3
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-18	1/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Page 2
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

3. Categorically Needy 300% of SSI

For the covered groups that use the 300% of SSI income limit, all income is counted (even excluded income) when screening at 300% of SSI. Do not count any monies which are defined as "what is not income" in S0815.000.

Family Size Unit	2023 Monthly Amount	*2024* Monthly Amount
1	$2,742	*$2,829*

4. ABD Medically Needy

a. Group I	*7/1/23-6/30/24*		*7/1/24*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$2,324.16*	*$387.36*	*$2,410.15*	*$401.69*
2	*2,925.70*	*493.11*	*3,068.11*	*511.35*

b. Group II	*7/1/23-6/30/24*		*7/1/24*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$2,681.739*	*$446.95*	*$2,780.95*	*$463.49*
2	*3,302.13*	*550.35*	*3,424.26*	*570.71*

c. Group III	*7/1/23-6/30/24*		*7/1/24*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$3,486.27*	*$581.04*	*$3,615.27*	*$602.54*
2	*4,202.86*	*700.47*	*4,358.35*	*726.39*

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/17/24

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/24

All Localities	2023		2024	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$11,664	$972	$12,048	$1,004
2	15,776	1,315	16,352	1,363
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$14,580	$1,215	$15,060	$1,255
2	19,720	1,644	20,440	1,704
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$17,496	$1,458	$18,072	$1,506
2	23,664	1,972	24,528	2,044
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$19,683	$1,641	$20,331	$1,695
2	26,622	2,219	27,594	2,300
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$29,160	$2,430	$30,120	$2,510
2	39,440	3,287	40,880	3,407

M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 1 and 18
TN #DMAS-31	4/1/24	TOC, Pages 1, 6, 7
TN #DMAS-30	1/1/24	Page 2
TN #DMAS-27	4/1/23	Pages 6, 7
TN #DMAS-26	1/1/23	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2
TN #DMAS-20	7/1/21	Page 16
TN #DMAS-19	4/1/21	Page 16
TN #DMAS-18	1/1/21	Page 2
TN #DMAS-17	7/1/20	Page 1
TN #DMAS-15	1/1/20	Page 2
TN #DMAS-12	4/1/19	Pages 10-10a
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-3	1/1/18	Page 2
TN #DMAS-4	4/1/17	Pages 10, 10a
TN #DMAS-3	1/1/17	Pages 2, 7, 10, 11 Page 10a was added as a runover page.
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 2
UP #9	4/1/13	Page 2
UP #6	4/1/12	Page 2
TN #96	10/1/11	Page 2
TN #95	3/1/11	Page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	Page 2
TN #91	5/15/09	Pages 14-16

OVERVIEW

M1110.001 ROLE OF RESOURCES

A. Introduction

As a program based on need, Medicaid uses the value of a person's countable resources as one of two financial criteria in determining eligibility. The other criterion is income. The following sections explain how to treat resources to determine eligibility in the Aged, Blind and Disabled covered groups in the Medicaid program. Virginia Medicaid follows Social Security Administration rules from the SSI section of the Program Operations Manual System (POMS) SSA's Policy Information Site - POMS. Some of the rules are adapted due to state laws and regulations. We have noted in each section if the section follows SSA policy without deviation by adding "per POMS'. This chapter explains how we count resources.

B. Policy Principles

1. Monthly Determinations

Eligibility with respect to resources is a determination made for each calendar month, beginning with the month of application or, if retroactive eligibility is being determined, the third month prior to the month in which the application is submitted. Resource eligibility exists for the full month if countable resources were at or below the applicable resource limit for any part of the month. *If resource amounts reported are reasonably compatible with values received from electronic verification sources, the evaluation can continue. If reported resource amounts and verified resource amounts are both below the established limit, resource eligibility is assumed to exist. If both amounts are over the resource limit, the applicant is not resource eligible. The sources of the resources do not need to match.*

2. Countable Resources

Not everything a person owns (i.e., not every asset) is a resource and not all resources count against the resource limit. The location of a resource does not by itself exclude the resource. "The Social Security Act and other Federal statutes require the exclusion of certain types and amounts of resources. Any assets that are resources but not specifically excluded are "countable." See:

- M1110.003 B.2. for the resource limits;
- S1110.100 for the distinction between assets and resources; and
- S1110.210 for a listing of exclusions.

3. Whose Resources Can Count

Medicaid law specifies that resources are only considered available between spouses and from parents to their children under age 21, and for certain blind and disabled children ages 18 to 21.

See M1110.530 for blind and disabled children age 18 to 21.

DETERMINING ELIGIBILITY BASED ON RESOURCES

M1110.600 RULE FOR MAKING DETERMINATIONS

A. Policy Principle--Rule

Make all resource determinations per calendar month. Resource eligibility exists for the full month if countable resources were at or below the resource standard for any part of the month. *If resource amounts reported are reasonably compatible with values received from electronic verification sources, the evaluation can continue. If reported resource amounts and verified resource amounts are both below the established limit, resource eligibility is assumed to exist. If both amounts are over the resource limit, the applicant is not resource eligible. The sources of the resources do not need to match.*

B. Policy Principle--Significance of the Rule

1. Increase in Value of Resources

Consider any increase in the value of an individual's resources in the resources determination the month following the month in which:

- the value of an existing resource increase (e.g., the value of a share of stock goes up or installment payments increase a property's equity value);
- an individual acquires an additional resource (e.g., inherits property); or
- an individual replaces an excluded resource with one that is not excluded (e.g., sells an excluded automobile for nonexcludable cash).

2. Decrease in Value of Resources

Consider any decrease in the value of an individual's resources in the resource determination the month in which:

- the value of an existing resource decreases (e.g., the value of a share of stock goes down);
- an individual spends a resource (e.g., withdraws $150 from a savings account to pay bills); or
- an individual replaces a countable resource with one that is not countable (e.g., trades a countable piece of real property for an excluded automobile).

3. Treatment of Assets Under Income and Resource Counting Rules

When an individual receives an asset (real or personal property) during a month, it is evaluated under the appropriate income-counting rules in that month. If the individual retains the item into the month following the month of receipt, it is evaluated under the resource-counting rules. Do not evaluate the same asset under two sets of counting rules for the same month.

Funds cannot be both income and a resource in the same month. Income that has been added to a bank account during the month must be subtracted from the ending balance to ensure that the income is not also counted as a resource. See M1140.200.

EXCEPTION: Trusts established on or after August 11, 1993, have different counting rules. See M1120.201.

M1140 Changes

Updated With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 1, 3 and 4
TN #DMAS-23	4/1/22	Table of Contents, page i Page 16 Table of Contents, page ii was added as a runover page. Pages 16a-16e were added. Page 16e is a runover page.
TN #DMAS-21	10/1/21	Page 26 Page 26a is a runover page.
TN #DMAS-20	7/1/21	Pages 18, 26a Page 19 is a runover page.
TN #DMAS-11	1/1/19	Page 17
TN #DMAS-7	1/1/18	Page 30
TN #DMAS-5	7/1/17	Page 7
UP #9	4/1/13	pages 2, 17
TN #97	9/1/12	Table of Contents, page i Table of Contents page ii was removed. pages 2, 16-19, 26, 26a
TN #96	10/1/11	pages 12-12a, 24
TN #93	1/1/10	pages 13-15 pages 24, 25
TN #91	5/15/09	pages 11-12a

TYPES OF COUNTABLE RESOURCES

*M*1140.001 PURPOSE OF SUBCHAPTER

Introduction

This subchapter contains instructions for the development of resources whose value ordinarily will count toward the resource limit. Use these instructions only after you have made certain that the property at issue:

- is a resource, based on instructions in the S1110 and S1120 subchapters; and
- is not an excluded resource, based on instructions in the S1130 subchapter.
- *The reported values of the resources are not reasonably compatible with electronic sources AND below the resource limit. See M1110.600.*

M1140.010 GENERAL VERIFICATION REQUIREMENTS -- INITIAL APPLICATIONS

A. Development and Documentation-- Any Resources

1. General Rule: Verify

Except as indicated in 2. and B. below, always verify the value of resources for any month for which you must determine eligibility.

If an applicant appeals a denial related to a particular resource, the evidence in the file must clearly establish the value of that resource. It must do so even if the issue under appeal is not the value itself (e.g., when the issue under appeal is ownership). This requirement ensures that at each level in the appeals process, the file contains complete documentation of the resource in question.

2. Exceptions to the General Rule

You do not have to verify the value of resources for a given month if:

- the resource is **totally** excluded, regardless of its value; or
- the individual is ineligible for that month for a nonfinancial reason.

3. Values That Apply to Resources

See S1140.042 and M1110.400 for detailed instructions on "current market value (CMV) and "equity value" (EV).

Develop the EV of a resource whenever:

- the CMV of all countable resources exceeds the applicable limit; and
- the individual alleges a debt against the resource.

You do **not** have to develop the EV for a resource if the CMV of all countable resources does not exceed the applicable limit.

See S1110.510 for developing the value of a resource when there is a **shared ownership**.

*M*1140.020 GENERAL VERIFICATION REQUIREMENTS -- POSTELIGIBILITY

A. Development and Documentation— Any Resources

Evaluation of continued eligibility is required for redetermination and changes. Different types of Medicaid coverage may require additional months to be evaluated, i.e., QMB and SLMB reevaluation may require retroactive and ongoing medically needy evaluation. The following instructions apply to any period of review.

1. Value During Past Months

a. Reasonable Compatibility
You do not have to verify the value of resources for a period of review if the reported values of the resources are reasonably compatible with electronic sources AND below the resource limit (resource eligible), or both values are over the resource limit (resource ineligible). See M1110.600.

b. **Ineligibility for Entire Period**
You do not have to verify the value of resources for a period of review, **if** for the **entire** period, the individual is ineligible because of a nonfinancial reason.

c. **Eligibility for One or More Months**
Verify the value of resources for any month being reviewed for which the individual is not ineligible based on a. above.

2. Value in Current Month

As at initial application, always verify the value of resources for any month for which you must determine eligibility.

You do not have to verify the current value of resources if the individual is ineligible for a nonfinancial reason.

3. Developing Value When An Appeal is Filed

See S1140.010A.1. if an individual appeals a termination of Medicaid coverage due to the value of particular resource.

B. Development and Documentation--Non-Liquid Resources

1. General Rule-Apply Current Value

Use the current value of a nonliquid resource in determining resources for any months evaluated due to redetermination or change unless:

- the specific instructions for developing that resource say not to; or
- evidence indicates that it would be inappropriate to do so, as may be the case with a resource that continually appreciates in value.

2. Exception Chart

If the resource is...	then see...	regarding
real property	S1140.100 D.2	use of the tax-assessed value.
foreign property	S1140.100 G.3	the retroactive application of current foreign exchange rates
an automobile	M1130.200 C.4	use of the current N.A.D.A Guide.

C. Development and Documentation-Liquid Resources

1. General Rule--Verify — Verify the value of liquid resources for each month covered by an application unless 2 *or 3* below applies.

2. Exception--Cash — As in initial, accept the individual's allegation.

3. Reasonable Compatibility — *If the reported values of the resources are reasonably compatible with electronic sources AND below the resource limit (resource eligible), or both values are over the resource limit (resource ineligible) no additional development is required. See M1110.600.*

D. Related Policy

1. Photo-copying Restrictions — See M1140.010 D. for photocopying restrictions imposed by Federal or State law.

2. Current Market Value/Equity Value — See M1110.400 for detailed instructions on CMV and EV.

See M1140.010 A.3. for what values to apply to resources.

3. Shared Ownership — See S1110.510 for developing the value of a resource when there is shared ownership.

4. Determining Equity Value — See S1140.042.

S1140.030 OWNERSHIP

A. Operating Policy--Liquid Resources

1. Assumption — For presumably liquid resources (S1110.305), assume that the person whose name is shown as owner owns the entire resource. If more than one owner is shown, assume that each has equal ownership interest.

2. Exceptions: Checking/ Savings Accounts and Time Deposits — See S1140.200 and S1140.205 for checking and savings accounts. See S1140.210 for time deposits.

B. Operating Policy-Nonliquid Resources — For presumably nonliquid resources (S1110.310), assume, absent some indication to the contrary, that an individual's allegation of sole ownership is correct.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 4a
TN #DMAS-31	4/1/24	Page 3, 35
TN #DMAS-30	1/1/24	Pages 11 and 19
TN #DMAS-26	1/1/23	Pages 3, 35
TN #DMAS-24	7/1/22	Pages 11, 47, 48
TN #DMAS-23	4/1/22	Pages 12, 23
TN #DMAS-22	1/1/22	Pages 3, 35
TN #DMAS-18	1/1/21	Pages 3, 35
TN #DMAS-15	1/1/20	Pages 3, 35
TN #DMAS-14	10/1/19	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

M1460.160 LONG-TERM CARE PARTNERSHIP POLICIES

A. Introduction

A Long-term Care Partnership Policy (Partnership Policy) is a type of LTC insurance. Under section 6021(a)(1)(A) of the Deficit Reduction Act (DRA) of 2005 states were permitted to develop LTC partnerships. In addition to paying for assisted living or long-term care services, a Partnership Policy allows for additional assets to be disregarded in the Medicaid eligibility determination.

The value of assets disregarded in the Medicaid eligibility determination is equal to the dollar amount of benefits paid to or on behalf of the individual as of the month of application, even if additional benefits remain available under the terms of the policy.

The Partnership Policy disregard is not applicable to the resource assessment for married individuals with a community spouse. See M1480 for more information regarding resource assessments and Partnership Policies.

B. LTC Insurance Policy Issued Prior to 9/01/2007

LTC policies issued prior to 9/01/2007 are **not** Partnership Policies. See M1470.230 B.*7*, *and* M1470.430 B.5 for more information regarding these types of insurance policies.

C. LTC Insurance Policy Issued on or After 9/01/2007

LTC policies issued on or after 9/01/2007 may or may not be Partnership Policies. For a policy to be considered a Partnership Policy, it must meet the following conditions:

- issued on or after 09/01/2007,
- contain a disclosure statement indicating that it meets the requirements under § 7702B(b) of the Internal Revenue Service Code of 1986, and
- provide inflation protection:
    - under 61 years of age, compound annual inflation protection,
    - 61 to 76 years of age, some level of inflation protection, or
    - 76 years or older, inflation protection may be offered, but is not required.

Obtain a copy of the Partnership Disclosure Notice and the LTC Partnership Certification Form (See M1460, Appendices 1 and 2) for verification of the requirements noted above. Also, verification of the amount of benefit paid to or on behalf of an individual as of the month of application must be obtained. This can be found on the Explanation of Benefits statement or by calling the insurance carrier.

Partnership Policies that are issued in other states may or may not meet Virginia's requirements. Please contact your Medicaid Consultant to verify reciprocity with Virginia.

Verifications and documentation regarding a Partnership Policy must be kept with other permanent verifications in the case record.

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 17-18a
TN #DMAS-31	4/1/24	Page 8a, 17
TN #DMAS-30	1/1/24	Pages 3, 7, 18c, 66, 69, 70
TN #DMAS-29	10/1/23	Page 66
TN #DMAS-26	1/1/23	Pages 7, 18c, 66, 69, 70
TN #DMAS-25	10/1/22	Page 66
TN #DMAS-24	7/1/22	Pages 8a, 8b, 13, 50b, 51, 55, 57, 66, 87, 89, 91
TN #DMAS-22	1/1/22	Pages 7, 18c, 66, 69, 70
TN #DMAS-21	10/1/21	Page 66
TN #DMAS-20	7/1/21	Pages 66, 70
TN #DMAS-18	1/1/21	Page 7, 18c, 66, 69, 70, 92
TN #DMAS-17	7/1/20	Pages 8b, 9, 14, 66, 77, 92
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70 Page 2 is a runover page.
TN #DMAS-14	10/1/19	Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51

On the Medicaid Resource Assessment form the worker lists the couple's resources as of December 1, 1995 as follows:

Resource	Owner	Countable	Countable Value
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	$100,000
CD	Mr	Yes	$31,000

$131,000 Total Value of Couple's Countable Resources
$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount ($65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

F. Notice Requirements

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

M1480.225 INABILITY TO COMPLETE THE RESOURCE ASSESSMENT-UNDUE HARDSHIP

A. Policy

Federal law states that a resource assessment must be completed on all Medicaid applications for institutionalized individuals who have a community spouse. On occasion, however, it is difficult to comply with this requirement because the applicant is unable to establish his marital status or locate a separated spouse, or the community spouse refuses or fails to provide information necessary to complete the resource assessment. *A claim of undue hardship cannot be made on a denied or closed Medicaid case or when the individual is deceased.* In situations where the applicant is unable to provide information necessary to complete the resource assessment, undue hardship can be claimed if each of the following criteria is met:

1. The applicant establishes by affidavit specific facts sufficient to demonstrate (a) that he has taken all steps reasonable under the circumstances to locate the spouse, to obtain relevant information about the resources of the spouse, and to obtain financial support from the spouse (including information about any legal proceedings initiated, protective orders in effect, etc.); and (b) that he has been unsuccessful in doing so;

   Absent extraordinary circumstances, determined by DMAS, the requirements of A.1 (a) cannot be met unless the applicant and spouse have lived separate and apart without cohabitation and without interruption for at least 36 months.

2. Upon such investigation as DMAS may undertake, no relevant facts are revealed that refute the statement contained in the applicant's affidavit, as required by paragraph A.1.

3. The applicant has assigned to DMAS, to the full extent allowed by law, all claims he or she may have to financial support from the spouse; and
4. The applicant cooperates with DMAS in any effort undertaken or requested by DMAS to locate the spouse, to obtain information about the spouse's resources and/or to obtain financial support from the spouse. *If the applicant cannot complete the Resource Assessment due to a medical condition, a physician's statement must be provided documenting the medical condition.*

B. Procedures

1. Assisting the Applicant

The *Benefits Worker* must advise the applicant of the information needed to complete the resource assessment and assist the applicant in contacting the separated spouse to obtain resource and income information.

If the applicant cannot locate the separated spouse, document the VaCMS case record. Refer to M1480.225 B.2.b below.

If the applicant locates the separated spouse, the *Benefits Worker* must contact the separated spouse to explain the resource assessment requirements for the determination of spousal eligibility for long-term care services.

If the separated spouse refuses to cooperate in providing information necessary to complete the resource assessment, document the VaCMS case record. Refer to M1480.225 B.2.b below.

EXCEPTION: If the separated spouse is institutionalized and is a Medicaid applicant/recipient, the definition of "community spouse" is not met, and a resource assessment is not needed.

2. Undue Hardship

If the applicant is unable to provide the necessary information to complete the resource assessment, he/she must be advised of the hardship policy and the right to claim undue hardship.

a. **Undue hardship not claimed**

If the applicant does not wish to claim undue hardship, the *Benefits Worker* must document the VaCMS case record, and the application must be processed using rules for non-institutionalized individuals. Payment for *LTSS* services must be denied for failure to verify resources held at the beginning of institutionalization.

b. **Undue hardship claimed**

If the applicant claims an undue hardship, he must provide a written statement requesting an undue hardship evaluation. A Resource Assessment Undue Hardship Request Form, including affidavit and assignment forms, may be given to the applicant to be used instead of an original statement but is **not required**. The forms are available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms.

1) Applicant or Authorized Representative

The applicant or his authorized representative must provide a letter or the Resource Assessment Undue Hardship Request Form – DMAS-E10 indicating the following:

- The applicant is requesting an undue hardship evaluation;
- The name of the applicant's attorney-in-fact (i.e. who has the power of attorney) or authorized representative (if applicable);
- The length of time the couple has been separated;
- The name of the estranged spouse and his
  - Last known address,
  - Last known employer,
  - The types (i.e. telephone, in-person visit) and number of attempts made to contact the spouse:
    - Who made the attempt
    - Date(s) the attempt(s) were made,
    - The name of the individual contacted and relationship to estranged spouse; and
- Any legal proceeding initiated, protective orders in effect, etc.

If not included with the request, the applicant or authorized representative may also be asked to provide:

- A completed, signed, and notarized Affidavit Form (DMAS-E11);
- A signed and dated Assignment Form (DMAS-E12)

A completed Resource Assessment Undue Hardship Request Form (including the affidavit and assignment forms) may be used instead of a letter from the worker but is **not required**.

2) *Benefits* Worker

A cover sheet is to be prepared that includes the following information:

- The applicant's name and case number;
- Documentation of any actions the *Benefits Worker* took to locate or contact the estranged spouse; and
- Include any documentation provided by the applicant or authorized representative.

The cover sheet and all information supporting the claim must be sent to:
DMASEvaluation@dmas.virginia.gov

Or mailed to:
Eligibility *Policy and Outreach* Division – Policy Unit
DMAS
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines that undue hardship does not exist, and the resource assessment cannot be completed, the *Benefits Worker* must deny the application due to failure to verify resources held at the beginning of institutionalization.

If DMAS determines an undue hardship does exist, the *Benefits Worker* will be sent instructions for continued processing of the case.

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 2b
TN #DMAS-31	4/1/24	Pages 7 and 8
TN #DMAS-30	1/1/24	Page 1, 2a, 8a,
TN #DMAS-24	7/1/22	Pages 8, 9a, 12-14
TN #DMAS-22	1/1/22	Page 8a Page 8 is a runover page.
TN #DMAS-21	10/1/21	Page 9a
TN #DMAS-19	4/1/21	Pages 6, 8
TN #DMAS-18	1/1/21	Pages 2b, 9, 12
TN #DMAS-17	7/1/20	Page 15
TN #DMAS-16	4/1/20	Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Pages 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7

C. Budget Periods By Classification

1. CN

The retroactive budget period for CN covered groups (categories) is one month. CN eligibility is determined for each month in the retroactive period, including a month(s) that is in a prior spenddown that was not met. Do not determine eligibility for a retroactive month that was included in a previous Medicaid coverage period; the applicant has already received Medicaid for that month.

NOTE: There is never any retroactive eligibility or entitlement as a Qualified Medicare Beneficiary (QMB) only. An individual who is eligible as Special Low-income Medicare Beneficiary (SLMB) or Qualified Disabled & Working (QDWI) can have retroactive coverage as an SLMB or QDWI.

2. MN

For the retroactive period, the **MN budget period is always all three months**. Unlike the retroactive CN period, the retroactive MN budget period may include a portion of a prior Medicaid coverage or spenddown period, and may also include months in which he is eligible as CN.

D. Verification

The applicant must verify all eligibility requirements in a retroactive month in order to be eligible for Medicaid coverage in that month.

Income verification from available electronic sources is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9). For all case actions effective October 26, 2019, if the income attested to by the applicant is within *20*% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required.

If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a Medically Needy (MN) covered group, verification of income **is required** to determine spenddown liability.

If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

An applicant with a resource test must provide verification of resources held in the retroactive period.

An individual who provides proof of application for an SSN, after he applies for medical assistance, meets the application for SSN requirement in the three months retroactive to his medical assistance application.

If the applicant fails to verify any required eligibility factor for a retroactive month, coverage **for that month** must be denied because of failure to verify eligibility. If he verifies all eligibility factors for the other months in the retroactive period, he may be eligible for CN retroactive coverage for those months.

EXAMPLE #1: Ms. A applied for Medicaid for herself and her children on July 8. She reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. She currently receives Unemployment Compensation as she lost her job in May. She provided all required verification for May and June, but did not provide income verification for April. Their application was approved for CN Medicaid coverage beginning May 1; April coverage was denied because of failure to verify income for April.